Client History Form

Client Name _____ Date of Birth_____

Current Concerns:

1) What concerns bring you to counseling?
   _____

2) How long have you been experiencing these issues? _____

3) Who recommended you seek counseling? _____

4) What have you tried previously to resolve these issues? Was it helpful?
   _____

5) Have you seen a counselor previously? If yes, please describe.
   _____
   Previous counselor's name and contact information:
   _____

6) What would you like to accomplish in counseling?
   _____

7) Who do you consider your supports?
   _____

8) What are your coping skills? Previous and current.
   _____

Medical History:

1) Are you currently under a medical doctor's care? Yes _____ No_____
   If yes, condition for which you're being treated: _____

2) List any health problems in the past or present (including chronic or serious illness, accident, head injury, or seizure) _____

3) Date of most recent physical exam? _____
   Primary Care Physician: _____

4) Additional doctor(s) involved in your care:
   _____

5) List any allergies_____

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6) Prescription and over the counter medications currently in use: None _____

Medication:	Dosage/ Frequency:	Reason Prescribed:
_____	_____	_____
_____	_____	_____
_____	_____	_____

7) Vitamins/Supplements currently in use: None _____

_____ _____ _____
_____ _____ _____

8) List current sleep habits and concerns: _____

9) List current eating/ dietary habits and concerns: _____

10) List current exercise routine: _____

Mental/ Behavioral Health/Substance History:

1) List any counseling you have had in the past:

Where?	By Whom?	Issue?	Dates?
_____	_____	_____	_____
_____	_____	_____	_____

2) List any substance or addiction treatment you have received in the past:

Where?	By Whom?	Issue?	Dates?
_____	_____	_____	_____
_____	_____	_____	_____

3) Do you currently have any self – harming or suicidal thoughts? No _____ Yes _____
If yes, please describe_____

Have you had any of these thoughts, behaviors or attempts in the past? No _____ Yes _____
If yes, please explain _____

4) Do you currently have any thoughts to harm or kill others? No _____ Yes _____
If yes, please describe_____

Have you had any of these thoughts, behaviors or attempts in the past? No _____ Yes _____
If yes, please explain _____

5) Do you ever hear voices or see things that other people don't see or hear? No _____ Yes _____
If yes, please explain _____

6) Have you been hospitalized for mental health or substance use issues? No _____ Yes_____
If yes, please provide name of hospital, reason and date:
_____

7) Do you have any family members or friends who have completed a suicide? If yes, please provide relationship and date: _____

8) Do you currently take any psychotropic medication?

Medication:	Dosage/ Frequency:	Reason Prescribed:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name and contact information of prescriber:

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9) Have you experienced any abuse? No _____ Yes _____
If yes, type of abuse: Physical_____ Sexual_____ Emotional _____ Other _____
By whom? _____
Describe any problems you have related to the abuse: _____
Do you believe you have the potential for hurting others? _____

10) Have you experienced any significant losses in your life? No _____ Yes _____
If yes, please explain: _____

Childhood:

Information regarding parents or guardian(s) who raised you.

1) Parent/ guardian name: _____
Relationship to client: _____
Current age: _____ Occupation: _____
Describe their personality: _____
_____
Describe any use of substances: _____
Methods of discipline: _____
Describe relationship with parent/ guardian: _____
_____

2) Parent/ guardian name: _____
Relationship to client: _____
Current age: _____ Occupation: _____
Describe their personality: _____
_____
Describe any use of substances: _____
Methods of discipline: _____
Describe relationship with parent/ guardian: _____
_____

3) Did parents or family members ever receive treatment for mental health issues? No _____ Yes _____
If yes, please describe_____

4) List any other adults who were important to you and how they affected your childhood:
_____

5) List siblings oldest to youngest, including yourself and any deceased siblings:
Name Age How they related to you as a child
_____
_____
_____
_____

6) Where do family members currently reside?
_____
_____

7) Where were you: Born? _____ Raised? _____

8) How many places did you live during childhood? _____
Reasons for moving? _____

Education:

1) What were grade school and high school like for you? Please describe:
_____
_____
_____

2) Last grade completed _____ Average grades: _____

3) List any issues that affected your learning and/ or education:
_____

Religious/ Spiritual beliefs:

1) What religious/ spiritual beliefs did you have during your childhood?
_____

2) Describe your current religious/ spiritual preference:
_____

3) How does spirituality affect your life?
_____

Social Activities:

1) How do you spend your free time? _____

2) Who do you spend most of your free time with?
Family _____ Friends _____ Alone _____

Adult Relationships:

1) Present partner's name _____
Age: _____ Occupation: _____
2) Describe your partner:
_____
_____
Partner's use of alcohol/ substances:
_____

3) Describe any issues in the relationship:
_____
_____

4) Previous relationships:
Name Age Why separated
_____
_____

5) What were your impressions of sex during childhood?
_____
_____

6) Is sexuality currently a problem for you? If yes, please explain:
_____
_____

Children:
(Please include any placed for adoption or deceased)
Name Age By Whom Current relationship
_____
_____
_____
_____

Work History:

1) What types of work have you done?
_____

2) What is the longest you have worked at a job? _____

3) What do you consider your main career? _____

4) Current employer: _____ Position: _____

5) Describe any financial problems: _____

Legal:

1) Current legal involvement? _____

2) Charges – Type and date _____

Signature of Client/ Guardian: _____ Date:_____

Signature of Therapist: _____ Date: _____

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